TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUBCHAPTER b: ASSISTANCE PROGRAMS

PART 123
COVERING ALL KIDS HEALTH INSURANCE PROGRAM

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Section

AUTHORITY: The Covering All Kids Health Insurance Program Act [215 ILCS 170] and Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13].

SOURCE: Added by emergency rulemaking at 30 Ill. Reg. _____, effective May 17, 2006, for a maximum of 150 days.

SUBPART A: GENERAL PROVISIONS

Section 123.100 General Description
EMERGENCY

This Part implements the Covering All Kids Health Insurance Program Act [215 ILCS 170] that authorizes the Department to administer an insurance program to offer all uninsured children in Illinois access to health insurance. The Department shall provide health benefits coverage to eligible individuals through purchasing or providing health care benefits.

Section 123.110 Definitions
EMERGENCY

For the purpose of this Part, the following terms shall be defined as follows:

"Act" means the Covering All Kids Health Insurance Program Act [215 ILCS 170].

"Department" means the Department of Healthcare and Family Services and any successor agencies.

"Family" means the child applying for the Program and the following individuals who live with the child:

The child's parents

The spouse of the child's parent

Children under 19 years of age of the parents or the parent's spouse

The spouse of the child
The children of the child

If any of the above is pregnant, the unborn children.

"Federal Poverty Level" means the federal poverty income guidelines as established by the federal Department of Health and Human Services and published in the Federal Register.

“Health Insurance” means any health insurance coverage as defined in 215 ILCS 105/2.

"Medical Assistance" means health care benefits provided under Article V of the Illinois Public Aid Code.

“Practitioner” means a physician (including a hospital billing a physician office visit), osteopath, podiatrist, optometrist, chiropractor, nurse practitioner, Federally Qualified Health Center, Rural Health Clinic or Encounter Rate Clinic.

"Program" means the program created under the Covering All Kids Health Insurance Program Act and this Part.

"Rebate" means the payment made by the Department under 89 Ill. Adm. Code 125.

"Resident" means resident as defined in 215 ILCS 170/10.

SUBPART B: GENERAL ELIGIBILITY AND ENROLLMENT

Section 123.200 Eligibility
EMERGENCY

A child may be eligible under the Program provided that all of the following eligibility criteria are met:

a) A child is not eligible for Medical Assistance including 89 Ill. Adm. Code 118.500 and 89 Ill. Adm. Code 120 or health benefits or rebates under 89 Ill. Adm. Code 125;

b) A child is under 19 years of age;

c) A child is a Resident of the State of Illinois; and

d) The child meets one of the following:

1) Upon initial determination of eligibility:

A) If the application is received during calendar year 2006, the child has been without Health Insurance at least since January 1, 2006, or, if application is made after December 31, 2006, the child has been without health insurance for at least 12 months prior to the date of application;

B) The child lost employer-sponsored Health Insurance when the child's parent's job ended;

C) The child has no Health Insurance and is less than one year old in the month of application for All Kids;

D) The child has exhausted the life-time benefit limit of his or her Health Insurance;

E) The child's Health Insurance is purchased under the provisions of Consolidated Omnibus Budget Reconciliation Act (COBRA)*;*

F) The child was disenrolled for Medical Assistance under 89 Ill. Adm. Code 118.500 or 89 Ill. Adm. Code 120 or health benefits or Rebates under 89 Ill. Adm. Code 125 within one year of applying under this Part; or

G) The child has health insurance provided by the child's noncustodial parent and the child's custodian is unable to access such health insurance benefits for the child.

2) Upon redetermination of eligibility:

A) The child was initially enrolled under subsections (d)(1)(A) or (F) of this Section; or

B) Affordable health insurance is not available to the child. For the purpose of this Section, affordable health insurance for the child does not exceed the amounts set forth below.

1) For a child who would be eligible for All Kids Premiums Levels 2 or 3, the cost of the monthly premium for coverage of all children seeking coverage under this Part does not exceed three percent of the Family's monthly countable income as determined under Section 123.230.

2) For a child who would be eligible for All Kids Premium Level 4, the cost of the monthly premiums for coverage of all children seeking coverage under this Part does not exceed four percent of the Family's monthly countable income as determined under Section 123.230.

3) For a child who would be eligible for All Kids Premium Levels 5-8, the cost of the monthly premium for coverage of the child does not exceed five percent of the Family's monthly countable income as determined under Section 123.230.

Section 123.210 Eligibility Exclusions and Terminations
EMERGENCY

a) An individual shall not be determined eligible for coverage under the Program if:

1) The individual is an inmate of a public institution.

2) The individual is a patient in an institution for mental diseases.

b) Termination of an individual's coverage under the Program shall be initiated upon the occurrence of any of the following events:

1) A child becomes ineligible due to:

A) Losing his or her Illinois residency.

B) Attaining 19 years of age.

C) Becoming enrolled in Medical Assistance under 89 Ill. Adm. Code 118 or 120 or for health care benefits or rebates under 89 Ill. Adm. Code 125.

D) Meeting the provisions of subsection (a)(1) of this Section.

E) The required premiums as specified in Section 123.330, are not paid.

F) The Family fails to report to the Department changes in information that impacts upon the child’s eligibility for the Program.

G) The Family makes a request to the Department to terminate the child’s coverage.

H) The Department determines that the child is no longer eligible based on any other applicable State or federal law or regulation.

I) The Department determines that an applicant failed to provide eligibility information that was truthful and accurate to the best of the applicant’s knowledge and belief and that affected the child’s eligibility determination.

J) The Department determines that the child's eligibility was incorrectly determined.

c) Following termination of a child's coverage under the Program, the following action is required before the child can be re-enrolled:

1) A new application must be completed and the child must be determined otherwise eligible;

2) There must be full payment of premiums due under this Part or 89 Ill. Adm. Code 125, for periods in which a premium was owed and not paid for the child;

3) Any overpayment of Rebates paid on behalf of the child under 89 Ill. Adm. Code 125 must be repaid to the Department. A Rebate overpayment shall be considered repaid if the Department can recoup the overpayment out of future Rebate payments;

4) If the termination was the result of non-payment of premiums, the individual must be out of the Program for three months before re-enrollment; and

5) The first month's premium must be paid if there was an unpaid premium on the date the child's previous case was canceled.

d) A certificate of prior creditable coverage will be issued when an individual's coverage is terminated under the All Kids/FamilyCare Health Plan.

Section 123.220 Application Process
EMERGENCY

a) Families will be able to apply for the Program using any of the following methods:

1) Submit the Department's application to an address specified by the Department.

2) Apply at a Department of Human Services (DHS) local office.

3) Apply through an All Kids Application Agent that has an agreement in place with the Department.

4) Apply online.

5) Additional methods that the Department establishes.

b) The application will meet all requirements found at 89 Ill. Adm. Code 110.10 including provisions regarding who may apply on behalf of a child.

c) Families are obligated to provide truthful and accurate information for determining eligibility and to report promptly to the Department any change in non-financial information provided on the application.

Section 123.230 Determination of Monthly Countable Income
EMERGENCY

Monthly countable income for applications processed for the Program is determined by taking the total gross monthly income of the Family and subtracting allowable deductions and exemptions as described in 89 Ill. Adm. Code 120, Subpart H.

Section 123.240 Eligibility Determination and Enrollment Process
EMERGENCY

a) If the monthly countable income is above 200 percent of the Federal Poverty Level and at or below 300 percent of the Federal Poverty Level for the number of individuals in the Family and all other eligibility requirements of this Part are met, the child will be enrolled in All Kids Premium Level 2.

b) If the monthly countable income is above 300 percent of the Federal Poverty Level and at or below 400 percent of the Federal Poverty Level for the number of individuals in the Family and all other eligibility requirements of this Part are met, the child will be enrolled in All Kids Premium Level 3.

c) If the monthly countable income is above 400 percent of the Federal Poverty Level and at or below 500 percent of the Federal Poverty Level for the number of individuals in the Family and all other eligibility requirements of this Part are met, the child will be enrolled in All Kids Premium Level 4.

d) If the monthly countable income is above 500 percent of the Federal Poverty Level and at or below 600 percent of the Federal Poverty Level for the number of individuals in the Family and all other eligibility requirements of this Part are met, the child will be enrolled in All Kids Premium Level 5.

e) If the monthly countable income is above 600 percent of the Federal Poverty Level and at or below 700 percent of the Federal Poverty Level for the number of individuals in the Family and all other eligibility requirements of this Part are met, the child will be enrolled in All Kids Premium Level 6.

f) If the monthly countable income is above 700 percent of the Federal Poverty Level and at or below 800 percent of the Federal Poverty Level for the number of individuals in the Family and all other eligibility requirements of this Part are met, the child will be enrolled in All Kids Premium Level 7.

g) If the monthly countable income is above 800 percent of the Federal Poverty Level for the number of individuals in the Family and all other eligibility requirements of this Part are met, the child will be enrolled in All Kids Premium Level 8.

h) Applicants will be notified, in writing, regarding the outcome of their eligibility determination.

i) Eligibility determinations for the Program made by the fifteenth day of the month will be effective the first day of the following month. Eligibility determinations for the

Program made after the fifteenth day of the month will be effective no later than the first day of the second month following that determination.

j) The duration of eligibility for the Program for children will be 12 months unless one of the events described in Section 123.210(a)(1) or (b)(1) occurs. The 12 months of eligibility will commence when the first child in a Family is covered under the Program. Children added to a family case after the eligibility period begins will be eligible for the balance of the 12-month eligibility period.

k) Children for whom application to the Program is made before the beginning of the fourth month following the month of the child's birth may obtain backdated coverage for a period beginning with the child's day of birth. This coverage shall be subject to the Family paying the premium(s) for the month(s) of backdated coverage requested.

Section 123.250 Appeals
EMERGENCY

a) Any person who applies for or receives benefits under the Program shall have the right to appeal any of the following actions:

1) Refusal to accept an application.

2) Denial of an application or cancellation at the annual renewal including denial based on failure to meet one or more of the eligibility requirements specified in this Part. If the denial or cancellation is not upheld on appeal, coverage under the Program shall be retroactive to the date the coverage would have commenced had the application or annual determination been approved. However, it will be at the Family's option whether coverage following a successful appeal shall be prospective only for the remainder of the 12-month period following application or retroactive to the date the coverage would have commenced had the application been approved. All premium and copayment requirements shall apply to the retroactive period.

3) Termination of coverage based on failure to continue to meet one or more of the eligibility requirements specified in this Part. If the termination is not upheld on appeal and benefits were not continued during the appeal, coverage under the Program shall be reinstated retroactive to the termination date. However, it will be at the Family's option whether coverage following a successful appeal shall be prospective only for the remainder of the 12-month period following application or retroactive to the date of termination. All premium and co-payment requirements shall apply to any retroactive period.

4) Determination of the amount of the premium, or copayments required. Coverage and any premium or copayment requirements, as determined by the Department, shall remain in force during the appeal process.

b) In addition to the actions that are appealable under subsection (a) of this Section, individuals shall have the right to appeal any of the following actions:

1) Termination of coverage due to non-payment of the required premium.

2) Denial of payment for a medical service or item that requires prior approval.

3) Decision granting prior approval for a lesser or different medical service or item than was originally requested.

c) Individuals may initiate the appeal process by:

1) Filing a written, signed request for a hearing directed to the Department's Assistance Hearings Section;

2) Calling a toll free telephone number designated by the Department.

d) The request for a hearing may be filed by the individual affected by the action or by the individual's authorized representative.

e) For purposes of initiating the appeal process, a copy of a written, signed request for a hearing is considered the same as the original written, signed request.

f) The request for a hearing must be filed no later than 60 days after notice of the appealable action has been given.

g) If an appeal is initiated within ten calendar days after the notice of intended Department action and the individual specifically requests that the benefits be continued, benefits shall be continued at the level in effect prior to the proposed action, pending the results of the fair hearing process. All copayment obligations including premiums must be met during the period.

h) The provisions of Subpart A of the Department's administrative rules at 89 Ill. Adm. Code 104, Practice in Administrative Hearings, shall govern the handling of appeals and the conduct of hearings under the Program.

i) An individual can, prior to a decision being rendered on the appeal, reapply for the Program.

Section 123.260 Annual Renewals
EMERGENCY

a) Eligibility shall be reviewed annually.

b) Prior to the 12-month eligibility period ending, and in sufficient time for the Family to respond to the Department's request for information, the Department or its designee will send an annual renewal notice to the Family.

c) Annual renewals shall be subject to all eligibility requirements set forth in Sections 123.200(a), (b), (c) and (d)(2) and 123.210 (a)(1).

Section 123.270 Adding Children to the Program and Changes in Participation
EMERGENCY

a) Families may add eligible children to the Program during the 12-month eligibility period. Coverage for newborns added to a case and for whom backdated coverage is approved as permitted under subsection 123.240(k) may begin with the child's date of birth. Coverage for all other children added to a case shall be prospective and for signed requests received by the fifteenth day of the month shall be effective on the first day of the month following receipt of the signed request. Signed requests to add a child received after the fifteenth day of a month will be effective no later than the first day of the second month following receipt of the signed request. Eligibility shall continue for the remainder of the 12-month eligibility period that began with coverage of the first child in the family. Such addition of a child shall not result in a review of the Family's financial eligibility for the program.

b) Premium amounts will be adjusted to reflect adding or removing a child from the Program subject to the limitations set forth in Section 123.330(a).

SUBPART C: ALL KIDS PREMIUM LEVELS 2-8 HEALTH PLAN

Section 123.300 Covered Services
EMERGENCY

Covered health care services shall be the same as covered services for children described at 89 Ill. Adm. Code 125.300(a) except as provided in Section 123.310.

Section 123.310 Service Exclusions
EMERGENCY

The following health care services shall not be covered under this Part.

a) Non-emergency medical transportation.

b) Services provided only through a waiver approved under Section 1915(c) of the Social Security Act.

c) Over-the-counter drugs.

Section 123.320 Copayments and Cost Sharing
EMERGENCY

a) Copayments or cost sharing may be charged for services provided to a child by a health care provider as described below, except for practitioner visits scheduled for well-baby care, well-child care, age appropriate immunizations, preventative dental visits or family planning services.

b) Copayment and cost sharing requirements are as follows:

1) Practitioner office visit:

A) All Kids Premium Level 2 copayment: $10 per visit.

B) All Kids Premium Level 3 copayment: $15 per visit.

C) All Kids Premium Level 4 copayment: $20 per visit.

D) All Kids Premium Levels 5-8 copayment: $25 per visit.

2) Dental visits:

A) All Kids Premium Level 2 copayment: $10 per visit.

B) All Kids Premium Level 3 copayment: $15 per visit.

C) All Kids Premium Level 4 copayment: $20 per visit.

D) All Kids Premium Levels 5-8 copayment: $25 per visit.

3) Inpatient hospitalization:

A) All Kids Premium Level 2 cost sharing: $100 per admission.

B) All Kids Premium Level 3 cost sharing: $150 per admission.

C) All Kids Premium Level 4 cost sharing: $200 per admission.

D) All Kids Premium Level 5-7 cost sharing: 20 percent of Department's rate.

E) All Kids Premium Level 8 cost sharing: 25 percent of Department's

rate.

4) Hospital or Ambulatory Surgical Treatment Center outpatient encounter with a payable service on the Ambulatory Procedure List:

A) All Kids Premium Level 2 cost sharing: 5 percent of the Department's rate.

B) All Kids Premium Level 3 cost sharing: 10 percent of the Department's rate.

C) All Kids Premium Level 4 cost sharing: 15 percent of the Department's rate.

D) All Kids Premium Levels 5-7 cost sharing: 20 percent of the Department's rate.

E) All Kids Premium Level 8 cost sharing: 25 percent of the Department's rate.

5) Hospital Emergency Visit

A) All Kids Premium Level 2 copayment: $30 per visit.

B) All Kids Premium Level 3 copayment: $50 per visit.

C) All Kids Premium Level 4 copayment: $75 per visit.

D) All Kids Premium Level 5-8 copayment: $100 per visit.

6) Prescription drugs:

A) All Kids Premium Level 2 copayment: $3 for a 1 to 30-day supply of generic drugs or $7 for a 1 to 30 day supply of brand name drugs.

B) All Kids Premium Level 3 copayment: $6 for a 1 to 30-day supply of generic drugs or $14 for a 1 to 30 day supply of brand name drugs.

C) All Kids Premium Level 4 copayment: $9 for a 1 to 30-day supply of generic drugs or $21 for a 1 to 30 day supply of brand name drugs.

D) All Kids Premium Levels 5-8 copayment: $12 for a 1 to 30-day supply

of generic drugs or $28 for a 1 to 30 day supply of brand name drugs.

c) The out-of-pocket cost sharing expense a child shall incur for services under subsections (b)(3), (4) and (5) of this Section during the plan year July 1 to June 30 shall be limited as follows:

1) All Kids Premium Level 2 – $500 per child.

2) All Kids Premium Level 3 – $750 per child.

3) All Kids Premium Level 4 – $1,000 per child.

4) All Kids Premium Levels 5-7 – $5,000 per child.

5) All Kids Premium Level 8 – no maximum.

d) Providers will be responsible for collecting copayments under the All Kids Health Insurance Plan.

e) Providers may elect not to charge copayments. If copayments are charged, the copayment may not exceed the amounts established in Section 123.320(b).

f) The Department will not require providers to deliver services when copayments properly charged under the All Kids Premium Health Plans are not paid.

Section 123.330 Premium Requirements
EMERGENCY

a) Families with individuals enrolled in All Kids Premiums 2-8 must pay monthly premiums as follows:

1) All Kids Premium Level 2: $40 per month per child to a maximum of $80 per month for two or more children.

2) All Kids Premium Level 3: $70 per month per child to a maximum of $140 per month for two or more children.

3) All Kids Premium Level 4: $100 per month per child to a maximum of $200 per month for two or more children.

4) All Kids Premium Level 5: $150 per month per child.

5) All Kids Premium Level 6: $200 per month per child.

6) All Kids Premium Level 7: $250 per month per child.

7) All Kids Premium Level 8: $300 per month per child.

b) Premiums are billed by and payable to the Department, or its authorized agent, on a monthly basis.

c) The premium due date will be the last day of the month preceding the month of coverage.

d) The premium will not increase during the eligibility period, unless the Family adds children to the coverage or there is a regulatory change in cost sharing.

e) The Family may at any time request a downward modification of the premium for any reason including a change of income, removal of a child from coverage or a change in family size.

Section 123.340 Non-payment of Premium
EMERGENCY

a) Children enrolled in All Kids Premium Levels 2-8 will have a grace period through the end of the month of coverage to pay the premium.

b) Failure to pay the full monthly premium by the last day of the grace period will result in termination of coverage.

c) Partial premium payments will not be refunded.

d) Collection action will be initiated by the Department to collect unpaid premiums.

Section 123.350 Provider Reimbursement
EMERGENCY

a) Provider participation under this Part shall be subject to approval by the Department to provide health care under the Illinois Public Aid Code.

b) Provider participation under this Part shall be voluntary.

c) Providers under this Part shall be reimbursed in accordance with the established rates of the Department or other appropriate State agency minus copayments or cost sharing as specified in Section 123.320(b)(1), (3), (4), (5) and (6), regardless of whether the patient share is collected. Copayments or cost sharing specified in Section 123.320 (b)(3), (4) and (5) will not be deducted once the child has reached the out-of-pocket cost sharing limit specified in 123.320(c).

d) Providers under this Part shall be prohibited from billing children covered under the All Kids Premium Levels 2-8 any difference between the charge amount and the amount paid by the Department other than the copayment and cost sharing amounts specified in Section 123.320.

e) Providers shall be responsible for refunding to the Family copayments and cost sharing collected in excess of the amounts permitted by this Part.